Request for Information:

Illinois Medicaid Health Systems Transformation and Implementation Consulting Services

Presented to:

State of Illinois Governor's Office of Management and Budget

Jim Pettersson
Managing Director
206.292.2385

January 24, 2014

NAVIGANT
HEALTHCARE

DISPUTES & INVESTIGATIONS • ECONOMICS • FINANCIAL ADVISORY • MANAGEMENT CONSULTING

NAVIGANT
HEALTHCARE

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January 24, 2014

Roma Barksdale Larson
Deputy General Counsel/Agency Procurement Officer
Governor's Office of Management and Budget
Room 603 Stratton Building
401 South Spring Street
Springfield, IL 62706

Re: Illinois Medicaid Health Systems Transformation and Implementation Consulting Services

Submitted via e-mail: roma.larson@illinois.gov

Dear Ms. Larson:

Navigant Consulting, Inc. (Navigant) is pleased to provide this submittal in response to the State of Illinois Governor's Office of Management and Budget RFI to explore options for the modernization of the State's Medicaid delivery system.

In our enclosed response, we highlight some of Navigant's experience that will enable us to support the State's ambitious reengineering of its delivery system. While our enclosed response highlights Navigant's pertinent qualifications, we typically supplement our Firm's capabilities and experience by partnering with subcontractors – both independent contractors with specialized expertise and other firms – so that we can be responsive to the needs of our clients. We engage these subcontractors as part of our proposed project team and, when needed, during the contract period to address unanticipated needs.

Based upon your review of our response, we would be pleased to further discuss how Navigant and its partners can support the State in implementing its healthcare reform initiatives.

We hope that you will include Navigant on your distribution list for any future Requests for Proposal resulting from this notice. Please feel free to contact me at (206) 292-2385 or at jpettersson@navigant.com with any questions.

Sincerely yours,

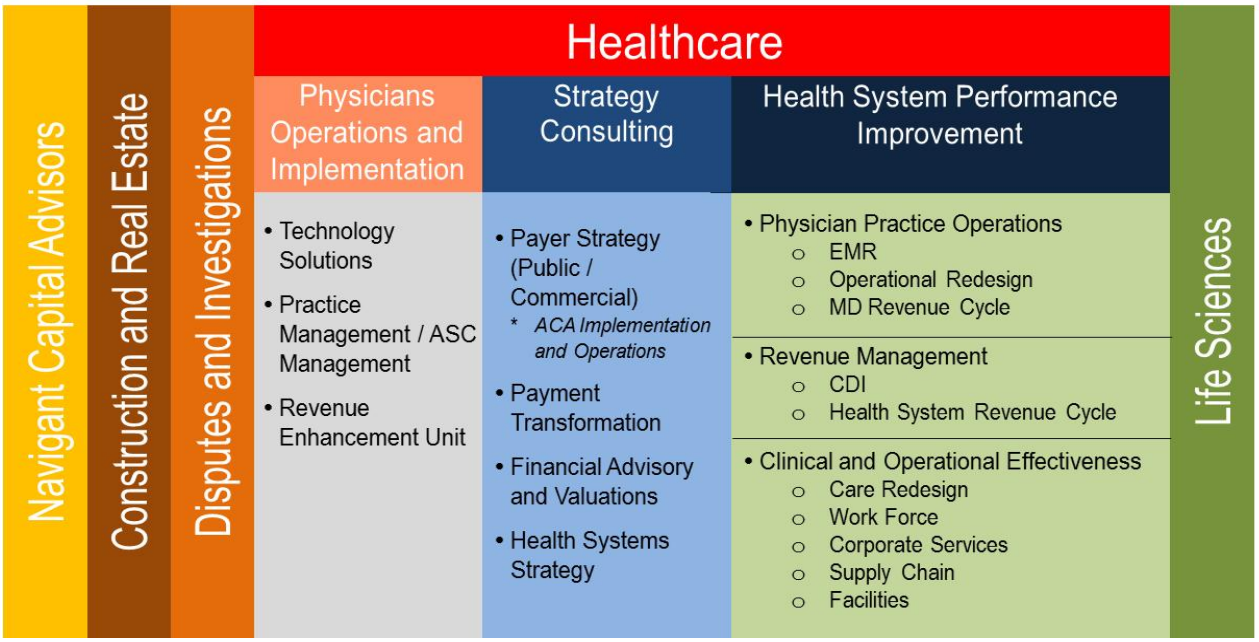
Jim Pettersson, Managing Director

Introduction to Navigant

Navigant Consulting, Inc. (Navigant), is a publicly traded (NYSE: NCI), independent consulting firm that focuses on industry sectors - like healthcare - that are highly regulated and undergoing significant change. Our healthcare practice is a nationwide network of more than 700 consultants who provide services to healthcare payers (including state and Federal governments), providers and life science companies to help improve their strategic, operational and financial performance. Navigant was incorporated in the State of Delaware on June 6, 1996 as The Metzler Group and on July 15, 1999 as Navigant Consulting, Inc. Navigant has grown elements of its business through acquisition, and several of these notable firms have been operating for more than 30 years. Navigant is headquartered in Chicago, Illinois and has approximately 2,800 full time equivalents in 45 offices across the United States. Our 2012 revenues were $845 million.

Our more than 700 professionals serve all segments of the healthcare industry – government programs, insurers and providers. As such, we are strongly and uniquely positioned to assist Illinois in understanding and addressing the potential impacts of its initiatives on providers, on commercial insurers, and on state vendors – and in effectively implementing the initiatives in a manner that will best position the State for a successful implementation that achieves the buy-in of the various stakeholders. Figure 1 below provides an illustration of our healthcare practice.

Figure 1: Navigant Healthcare – An Overview



Our ability to draw on experts from all areas within healthcare to respond to our clients' needs is unparalleled.

Our healthcare practice continues to build a strategic platform for payers and providers and support the development and implementation of solutions and tools that enable our clients to achieve what the Institute for Healthcare Improvement (IHI) calls the "Triple Aim":

- Improve the health of the population;
- Enhance the patient experience of care (including quality, access and reliability); and
- Reduce, or at least control, the per capita cost of care.

Although regulatory efforts, represented by Affordable Care Act (ACA), have served to accelerate certain competitive trends such as the move toward value-based healthcare, it continues to be competition and not reform that drives many markets. Toward that end, our focus will continue to be on creating clinical integration models that drive cost effective, high quality care.

We believe that what makes Navigant unique is our end-to-end understanding of healthcare delivery. We recognize the depth of the technical requirements for projects such as the magnitude of Illinois' potential modernization project which this RFI seeks to inform, how to manage and conduct complex projects and how to meet tight timelines efficiently.

For more than 25 years, our Healthcare Payer practice has helped states design and implement innovative programs.

We also understand the business-related impacts, implementation, coordination and adoption issues that our clients face – which is particularly important for Illinois, as it prepares to work with a broad swath of stakeholders to promote and effectively implement a new system. To this end, Navigant brings an in-depth understanding of existing healthcare regulations and operations combined with knowledge and experience to assist multi-payer initiatives with a variety of challenges.

Our experience in financial forecasting and modeling, technology and operations also allows us to bring together the client's vision, Federal and state regulations, other Federal initiatives and stakeholder demands into a cohesive business plan that allows our client to achieve its goals.

We have assisted more than a dozen state Medicaid agencies to design, implement, procure contractors for and monitor Medicaid managed care programs and to implement major government healthcare initiatives, including waiver programs. We have negotiated with the Centers for Medicare and Medicaid Services (CMS) with or on behalf of our state clients. We have developed communications strategies and materials for all audiences – from legislative, media and providers, to consumers and a wide range of other audiences.

Furthermore, we have led our clients through the complex process of Value Based Purchasing program design, including performance assessment, gap and root cause analysis, intervention development, measurement of performance and communication strategies and tools. We have designed and conducted retrospective and concurrent evaluations of demonstrations, pilot

programs and quality improvement and other initiatives. We have helped states to design and implement traditional and cutting-edge payment reforms – from DRGs to bundled payments, incentive payments and shared savings models. We have conducted program and operational reviews to assess the status quo and recommend changes needed to achieve the State's current targets or goals.

In the pages that follow, our responses to the RFI Questionnaire will provide a detailed description of the qualifications we believe are key for successfully performing the work that is the subject of this RFI. While our response highlights Navigant's pertinent qualifications, we typically supplement our Firm's capabilities and experience by partnering with subcontractors – both independent contractors with specialized expertise and other firms – so that we can be responsive to the needs of our clients. We engage these subcontractors as part of our proposed project team and, when needed, during the contract period to address unanticipated needs.

RFI Questionnaire

1. Describe your organization's expertise in implementing large healthcare systems delivery reform such as an 1115 Waiver, CMI State Innovation Model testing projects for developing multi-payer approaches to integrated healthcare delivery and similar innovative and transformative state government implementation efforts.

a.) The description should include reference to each of the six requirements indicated in the RFI.

The following cross-walk (Table 1) demonstrates how Navigant's qualifications (described on pages 5-26) map to the RFI Requirements.

Table 1: Qualifications Cross-Walk

RFI Requirement	Navigant Qualification Categories
1. Healthcare delivery systems transformation implementations.	A, B, C, D, E, F, G, I, J
2. 1115 Waiver implementations.	A, F
3. State government consulting practice with expertise in health and human services.	A, B, C, D, E, F, G, I, J
4. Medicaid business process modernization.	A, B, D, E, I, J
5. New Public Management vs. Old Public Administration methodology expertise.	A, B, E, J
6. Medicaid Information Technology Architecture ("MITA") knowledge to coordinate with the State's ongoing health and human services technology transformation.	A, C, E, H

A. Medicaid Programs

As a leader in Medicaid consulting, our firm is recognized for our hands-on experience in the design, implementation and monitoring of Medicaid delivery and financing systems. Many of our consultants have worked within health plans in top leadership and operational positions and in executive positions within various state governments and Federal agencies. We have assisted state Medicaid agencies in every phase of designing, developing, implementing, monitoring and supporting both managed care and innovative fee-for-service programs.

To demonstrate the breadth of our experience, we present our experience in terms of the overall program lifecycle.

Strategic Planning and Vision and Goal Setting

Our consultants have assisted more than a dozen state Medicaid agencies with strategic planning and program design and implementation. We have worked with Medicaid agencies and legislatures in many states to identify policy options and assist with development of implementation recommendations. We have covered topics ranging from provider payment methods to managed care program design and Medicaid expansions to Medicaid redesign and reform.

Currently, we are working with a legislatively appointed task force in one state to help assess approaches to new legislation calling for the implementation of Medicaid Accountable Care Organization (ACOs) and Patient Centered Medical Homes (PCMHs). Navigant's experience with managed care programs started with the design and development of Medicaid managed care programs.

Options Identification and Selection

States are increasingly pursuing new initiatives such as opportunities for enhanced match, waivers and major program reforms. Navigant helps states align the pursuit of new initiatives with their goals, resources and priorities. We also help state decision-makers consider the implications of pursuing these ideas, including the effort required, potential political fallout, stakeholder concerns, impact on quality and access to care and budgetary concerns.

Our consultants regularly work with states to identify and evaluate options for improved healthcare delivery. We employ a number of tools to aid in the evaluation of these options, including the Kepner-Tregoe[1] model, to objectively evaluate and select ideas. In addition, our work regularly includes review and iteration with appropriate state staff or stakeholders. Recently, we have worked with a number of states to identify and evaluate options, models and approaches for the improvement or redesign of care delivery models in their respective states.

[1] The Kepner-Tregoe Decision Analysis is a structured, step-by-step approach for systematically solving problems.

A. Medicaid Programs

Evaluation

Along with program strategy and design, program evaluation is a critical component when planning healthcare program change. States, other payers, plans and providers must be able to account for fiscal and policy decisions to justify their program expenditures, often answering to the Federal government, state legislatures, taxpayers and consumers. Program evaluations provide the necessary analysis to support and guide these decisions.

For example, Navigant is presently assisting a state Medicaid agency analyze and implement strategic options for managing the financing and care of the State's Medicaid and CHIP programs. We are in the process of facilitating task forces charged with identifying advantages and disadvantages to the proposed delivery systems and program design.

Our approach establishes an evaluation framework that is inclusive of a program's strategy and design so that we consider the entire picture. We assess whether a program is meeting expectations, and where our client can make improvements. We employ the full range of study designs – from exploratory case studies to large-scale studies using multi-variate statistical methods. We have conducted these evaluations at the behest of state legislators, for Medicaid agencies and to comply with Federal waiver requirements, and we tailor our approach accordingly. Evaluations can vary from complex statistical analyses to consumer survey findings, but for any analysis, the information must be reliable and answer the questions about the program's performance.

We have assisted numerous states with all facets of the design and development of Medicaid waiver programs, including 1115 Research and Demonstration programs, 1915(b) Medicaid Managed Care programs and 1915(c) Home- and Community-Based Services programs. Other examples of relevant experience include facilitating the development of a strategic plan for providing services to persons with disabilities in Illinois, assessing and recommending changes to the delivery of case management services across public healthcare programs in Texas, and designing and developing a Certified Expenditures Program and service delivery requirements for California school-based healthcare delivery.

REPRESENTATIVE CLIENTS AND PROJECTS:

LEGISLATURES

State of South Dakota ◆ Commonwealth of Virginia ◆ State of North Carolina

MEDICAID

Massachusetts Medicaid ACO Strategy ◆ Illinois Adequate Healthcare Task Force ◆ South Dakota Governor's Task Force on the Establishment of the Health Insurance Exchange ◆ State Medicaid Health Information Technology Plans in Kansas, Maryland, Pennsylvania and the District of Columbia and Landscape Assessment in Illinois ◆

A. Medicaid Programs

Medicaid MCO Procurement and Implementation Assistance in Colorado, Delaware, Georgia, Indiana, Kansas, Mississippi, New Hampshire, New Mexico, Pennsylvania, Tennessee, Texas and Virginia ◆ Wyoming Bi-Annual Strategic Plan ◆ California Medi-Cal Managed Care Dashboard Report and Study ◆ Washington Medicaid Workers Compensation and State Uninsured Fund ◆ Washington Medicaid RBRVS Development and Implementation ◆ Medicaid Redesign for Georgia ◆ Federal Waiver Negotiations and Applications (1915(b) and 1115) for Georgia, Idaho, Indiana, Ohio, Pennsylvania and Wyoming ◆ Waiver Program Evaluations for North Carolina, Pennsylvania, Texas and Wyoming

OTHER

Strategic Planning for Division of Developmental Disabilities in Arizona ◆ Facilitation of Advisory Groups, Work Groups or Steering Committees in Arizona, Arkansas, Colorado, Idaho, Illinois, Indiana, Kentucky, Massachusetts, Minnesota, Nebraska, New Hampshire, North Carolina, Pennsylvania, Texas, West Virginia, Washington and Wyoming, among others ◆ Support for Correctional Healthcare Services in California and Colorado

B. Medicaid Managed Care

Navigant is the premier firm assisting both states and Medicaid managed care health plans throughout the country. We partner with states on Medicaid managed care program implementation, performance measurement and reporting, as well as program evaluation, planning and improvement. We are experts at both qualitative and quantitative research methods and reporting. Our reports facilitate and foster "real-world" planning – supporting important decision-making processes and effective program management. We are currently working with a number of states to make recommendations regarding enterprise level, game-changing approaches to managed care that will help these states achieve their Medicaid program goals.

As a leader in Medicaid consulting, our firm is recognized for hands-on experience in the design, implementation and monitoring of Medicaid managed care programs and delivery systems. Our consultants bring deep knowledge and experience to each project, since many have worked within health plans in top leadership and operational positions and in executive positions within various state governments. Our consultants have assisted more than a dozen state Medicaid agencies with strategic planning and program design and implementation, as well as procurement and monitoring of contractors for Medicaid delivery systems and we have experience with Medicaid programs in more than 45 states.

Our consultants have extensive experience with planning, designing, pricing, implementing and evaluating full, risk-based managed care programs. Navigant also assists states with

B. Medicaid Managed Care

managed care program planning and procurement, including drafting waiver applications and cost projections, developing RFPs, proposal evaluation plans and evaluation criteria and health plan contracts, risk sharing design, as well as assisting with contract negotiations and conducting reviews to assess a health plan's readiness to accept enrollment.

While much of Navigant's managed care work has been on behalf of state Medicaid agencies, many of our projects require us to work directly with Medicaid managed health care plans. We develop Medicaid bid strategies on competitive bids for Medicaid managed care health plans and provide assistance in bid disputes and other litigation related to Medicaid procurements. We have conducted systems readiness reviews and assessments of information technology strategies for major health insurers. These reviews incorporate thorough technical reviews of the joint interface plans, disaster recovery plans, business continuity plans, risk management plans and systems quality assurance plans, testing prior to implementation and compliance with HIPAA requirements.

Highlights of our Medicaid managed care experience include:

- Development and implementation of strategic options for managing and financing state Medicaid programs including initiatives to support improved outcomes and quality of care for members.
- Development of dashboard reports that present a meaningful set of measures in a format that frames pertinent information and better positions state Medicaid agencies to manage risk, drive improvement and shape the future of its programs.
- Design of programs tailored to meet the unique needs of Medicaid subpopulations.
- Assistance with waiver design, implementation, evaluation and feasibility analyses.
- Working to transition states from voluntary to mandatory managed care or to transition out of managed care.
- Assistance to states as they develop programs involving managed care plans, enrollment brokers, primary care case management program administrators, disease management organizations and care management entities – as well as other innovative care management initiatives.
- Monitoring and technical assistance related to the ongoing operations of managed care and other programs in states with developing and mature Medicaid programs. This includes assisting with data collection and analysis, developing monitoring tools and reports and training state agency staff and vendors.
- Developing and performing ongoing monitoring activities including developing monitoring procedures and tools and defining performance standards. This consists of monitoring program and contract compliance, operational performance, financial performance, quality, provider network adequacy, encounter data

B. Medicaid Managed Care

reporting completeness and accuracy and payment accuracy. This also includes measuring performance in meeting EPSDT standards, quality standards, reporting requirements, claims processing timeliness, member services response times and compliance in processing grievances and appeals to name a few.

- Assisting commercial payers in the design, monitoring and evaluation of claims processing, enrollment and other information systems. For both our commercial and Medicaid clients, we have built a wide variety of managed care contractor and information systems monitoring tools.
- Design, procurement, evaluation and monitoring of primary care case management (PCCM) and Enhanced PCCM programs and related waivers. This work often includes assessing the feasibility of implementing PCCM programs and researching and analyzing other states' program designs.
- Assisting states in the development and the design of case management waiver programs, including the preparation of the cost-effectiveness analyses.

REPRESENTATIVE CLIENTS AND PROJECTS:

California HealthCare Foundation Dashboard Reporting System ◆ Georgia Medicaid and CHIP Redesign ◆ Pennsylvania Department of Public Welfare Implementation of Health Choices and Other Managed Care related Reforms ◆ Early Development of Managed Care Programs in Indiana, Kansas, New Jersey, New Hampshire, Oklahoma and Texas ◆ MississippiCAN Program Implementation Manager ◆ Design, Procurement, Evaluation and Monitoring of PCCM and Enhanced PCCM Programs in Illinois, Indiana, Kansas, Montana and Pennsylvania ◆Assess Feasibility of Implementing PCCM Programs for Oklahoma and Wyoming ◆ Indiana Managed Care Monitoring and Procurement Support

C. Large Scale Healthcare Reform Project Management

When states and the Federal government implement new programs, initiatives and programmatic changes, they often look to Navigant for program design, implementation and project management support. Navigant sets its project management approach within the larger framework of industry standards and best practices. We embrace the project management approach as defined by the Project Management Institute (PMI); many of our professionals are PMI-certified Project Management Professionals (PMPs). Our standard practice is to apply project management processes as defined by PMI and outlined in the PMBOK – Project Management Book of Knowledge (5th Edition), which provides standardized, regularly-audited project management and quality objectives and procedures

C. Large Scale Healthcare Reform Project Management

that support conformity of products and services.

We use various tools which allow us to plan sustainable implementation projects, track and document approvals along the lifecycle and determine whether the overall project and its underlying tasks and activities are running properly before large problems arise. Navigant is accustomed to working closely with its clients to identify (and modify as appropriate) project management tools to track and manage a number of projects being conducted simultaneously. Following is a representative sample of these tools:

- Project Quality Management Methodology as defined by the Project Management Institute
- Quality Assurance Surveillance Plan (QASP) utilizing a Surveillance Matrix to measure project performance against the established performance criteria
- Engagement staffing, including strategic partnering with individuals and firms having industry recognized certifications and experience
- Project Management Software (e.g., Microsoft Project)
- Issues Management (e.g., templates, reporting and databases)
- Risk Mitigation (e.g., assessment methodology, databases, reporting)
- Communication Plan methodology
- Project Measurements (e.g., budget, schedule, deliverable tracking, reporting, etc.)

Resource Allocation

Most of our projects include some level of assistance in identifying infrastructure, resource and management needs when new programs are implemented. We help clients determine if additional or fewer staff are required to support the program and the reorganization that may be required to support new functions. For example, if a particular state's Medicaid design solution involves operation of, or coordination with, the Federal Health Benefits Exchange, the state will need to determine how best to organize staff to support the streamlining of eligibility determinations. The state will also want to determine what the role of its enrollment broker will be and how it may need to change. State Medicaid agency staff will need training about the program to be able to respond to stakeholder questions and to perform their job duties. We have assisted with tasks from reorganizing departments and agencies, to defining job responsibilities and assisting with hiring. Navigant also places individuals in interim positions to support our clients in their efforts.

Design and Development of Standard Operating Procedures

Our experience has proven that the documentation of business operating processes and procedures is critical in defining the responsibilities, attributes, process flows and relationships necessary to realize the business objectives of any program. Navigant leverages

C. Large Scale Healthcare Reform Project Management

its first-hand experience in designing, implementing and managing complex government programs, applying insurance industry best practices and developing effective standard operating procedures (SOPs) for a number of healthcare-related programs. We have extensive experience in developing process models, SOPs and business requirements for non-healthcare related government programs and we bring these best practices from other industries and apply them in new ways to healthcare programs. Navigant's standard practice is to develop SOPs that clearly document project performance metrics, outline the requirements for success and enable uniformity of task execution. We also use SOPs to support training and quality assurance/quality control efforts.

Navigant recently worked with CMS to implement three ACA-related programs designed to protect insurance issuers from the negative effects of adverse selection and stabilize premiums for consumers in the individual and small group markets as insurance reform and Exchanges take effect in 2014. The systems CMS will use to perform program activities were under development; Navigant provided advisory and project management support to the development of business requirements for CMS' system developers. We developed business requirements that define "what" needs to happen and documented that understanding through process flows and relationships necessary to realize the business objectives of the project. The SOPs determine "how" tasks happen and describes them in terms of both functional and process work flow requirements. The SOPs developed will also serve as a solid performance metric which clearly defines successful implementation of a given contract task. Collectively, Navigant's business requirements and SOPs define and document the criteria necessary to design, build and operate CMS' information system.

REPRESENTATIVE CLIENTS AND PROJECTS:

HealthChoices Expansion Pennsylvania Department of Public Welfare (DPW) ACCESS Plus Implementation ◆ Office of Medical Assistance Programs (OMAP) – Health Information Technology ◆ State of Indiana - Various Managed Care Reform Initiatives ◆ State of Texas Managed Care Organization to Serve Foster Children ◆ Illinois Adequate Healthcare Task Force ◆ Idaho Waiver Feasibility and Program Development ◆ Georgia Medicaid and CHIP Re-Design ◆ Commonwealth of Pennsylvania Medicaid Exchange Planning ◆ Nebraska Exchange Implementation Planning ◆ State of South Dakota Governor's Task Force on the Establishment of the Health Insurance Exchange ◆ CMS Technical Assistance to CO-OP Health Plans ◆ CMS Outreach and Invoicing for Exchange Reinsurance and Risk Adjustment User Fees ◆ State of Mississippi Managed Care Roll-out ◆ California Department of Health Care Services Local Educational Agency Rate and Implementation

D. Alternative Healthcare Delivery Systems

Navigant is working with state and commercial payers across the nation to research, develop and implement innovative performance incentive funding models. States employ a variety of service delivery models for their Medicaid populations and many are considering or developing several others. Our approach is to work closely with states to explore and develop financial models that aid in the decision-making process.

Medical Home and Health Home Models

Navigant consultants have significant experience implementing the PCMH model and managing large and small physician practices. Members of the Navigant team have worked with North Carolina's PCMH model and CCNC (Community Care of North Carolina) senior leadership for more than a decade. The lessons learned from our first-hand experience with the nation's longest standing and most recognized Medicaid PCMH system will be invaluable to this engagement. We have also worked with state Medicaid agencies to evaluate and develop options for PCMHs within Medicaid, and have assisted other states' agencies and health plans in evaluating PCMH programs for their beneficiaries. We have also reconfigured practice sites into the PCMH model and prepared physician practices for NCQA recognition, providing us with in-depth knowledge of the challenges facing practices in obtaining certification.

Design and Development of Managed Care and Primary Care Case Management Programs

Navigant's experience with managed care programs started with the design and development of managed care programs for Medicaid. Our consultants worked with Arizona, the first Medicaid managed care model on a state-wide scale and the only state to date to have a fully capitated long-term care program. We have worked with a number of states and assisted in the early design and development of their managed care programs. We have also served as the implementation manager for these programs.

Our consultants have provided assistance to states with the design, procurement, evaluation and monitoring of PCCM and Enhanced PCCM programs in states such as Illinois, Indiana, Kansas, Montana and Pennsylvania. We have helped states such as Oklahoma and Wyoming assess the feasibility of implementing PCCM programs. We have researched and analyzed other states' program designs and assisted states in the development and design of case management waiver programs, including the preparation of the cost-effectiveness analyses. Our consultants have evaluated programs for access to, quality of and cost-effectiveness of care and developed plans for improvement. We have also assisted in all phases of procurement of administrative agents for the provision of case management services. Our work in this area began more than a decade

Navigant has 30 contracts with 19 states. We have worked with more than 150 CMS bundled payment program sites, 20 Medicare Shared Savings ACOs, six Pioneer ACOs and numerous Medicare Advantage and Medicaid Managed Care plans.

D. Alternative Healthcare Delivery Systems

ago, when managed care was becoming increasingly prevalent in Medicaid programs and when Medicaid programs were building some of the first and, often, very basic PCCM programs. Now, we are working or have worked with several states to assist with the design and implementation of Enhanced PCCM programs.

Payment Transformation

Navigant works with large healthcare payer and provider systems to assess their readiness to pursue new models of healthcare delivery. For example, for some of our clients, we have developed a three-year "Accountable Care Organization" roadmap that specifies configuration and implementation options for consideration; identifies a shortlist of immediate pilot opportunities, including high level design specifications; and that assesses its readiness to pursue an accountable care organization. We provide advice on how to strengthen payer/physician partnerships, identify cost/quality improvement areas and develop new payment methodologies.

We base our work on these payment transformation engagements on a few core principles honed from years of strategic, data driven engagements with the nation's leading payers and providers. This approach includes:

- Engaging key stakeholders in the issues that matter most
- Employing a data driven, scenario-based approach
- Pragmatically balancing early wins and process redesign

We have:

- Facilitated more than 25 payer/provider ACO/clinically integrated network/new Medicaid and Medicare contract engagements with commercial payers
- Provided application assistance to six of the 32 Pioneer ACOs, including conducting the planning and financial feasibility assessment and assisting with day-to-day project management for one of the nation's largest Pioneer ACOs

Value-based Purchasing Approaches to Payment

We are working currently with both payers and providers – including Medicaid payers – to develop shared savings models and bundled payment approaches, which are more consistent with value-based purchasing programs. Value-based purchasing moves payment from a fee-for-service model, which provides the maximum rewards for healthcare providers who deliver the most services. We are helping payers develop, for example, shared savings models, under which an organization is paid on a fee-for-service basis, but if it reduces the overall healthcare spending for its patients below the level that the payer would have otherwise expected, the organization is rewarded with a portion of the savings.

We are also developing, bundled payment approaches -- bundling is the process of grouping services for payment purposes – either for a particular person over a predefined period of time

D. Alternative Healthcare Delivery Systems

(i.e., global bundling) or for a person for a particular health event (i.e., episodic bundling). We are helping our clients implement episodic bundling programs to improve care delivery associated with specific health conditions. Bundled payment approaches offer payers the opportunity to change the way healthcare delivery systems are structured, allowing payers such as Medicaid to establish an integrated and coordinated care strategy. We have:

- Developed bundled payment approaches for state Medicaid agencies to pilot; these payment approaches have been used to support ACO development and other payment pilots.
- Developed Medicaid methodologies using numerous DRG groupers, including original Medicare grouper, MS-DRG grouper and APR-DRGs grouper. This included running a suite of proprietary Navigant tools to identify avoidable costs.
- Developed long-term strategies for provider payment for Medicaid agencies. These strategies include a discussion of other payers' approaches, fee schedule levels and recommendations for new strategies for payment.
- Helped states to develop performance-based contracting to reward organizations and providers for high quality performance and assist health plans in the development of quality metrics and pay for performance programs.
- Developed a nationally acclaimed quality payment model; benchmarked and reviewed calculations related to historical medical cost trends, risk adjustment methods, coding adjustment methods, quality metrics and scoring and final PMPM budgets.
- Helped providers and payers identify key unit cost and utilization savings targets and tactics across the care continuum, including emergency room utilization, specialty drugs, inpatient admissions and days.

Multi-Payer Strategies/Bundled Payment Approaches

Navigant is at the forefront of developing and implementing multi-payer strategies and a number of other innovative payment approaches designed to incent providers to contain costs and improve quality outcomes. Our dedicated team has deep strategy, actuarial, clinical and operations experience focused on the design and implementation of "bend the trend" strategies for providers and payers

We work with large, national plans to team with various health systems to create new models of delivery and financing. We have participated in ACO assessment, including market assessment, medical management review and design, product review and design services. We also have experience in developing innovative payment models for state Medicaid and other health purchasing agencies, Medicare and health plans. We regularly conduct complex healthcare cost trending analytics using proprietary tools and algorithms. We work with our

D. Alternative Healthcare Delivery Systems

payer clients to bundle payments and analyze avoidable costs, thereby providing opportunity for financial reward by finding ways to reduce unnecessary services and avoiding preventable complications and readmissions. For example:

- Developed our Next Generation Payment and Network Transformation tool to evaluate cost trends and simulates future state financial scenarios. We use this tool to assist payers and providers in the evaluation of provider performance relative to local, regional and national benchmarks; it also allows providers and payers to measure and track cost and utilization performance.
- Facilitated 25 payer/provider ACO/clinically integrated network/new contract engagements with commercial payers (Blues, etc.) on Medicaid, Medicare Advantage, etc., requiring extensive data analysis of all payer claims data. Our work included payment model assessment and implementation relative to global and service-level capitation, fee-for-service, bundles, guarantees and shared savings, case rate implementation, risk adjustment, internal funds flow and compensation and out-of-network.
- Provided application assistance to six of the 32 Pioneer ACOs, including conducting the planning and financial feasibility assessment and assisting with day-to-day project management for one of the nation's largest Pioneer ACOs.
- Developed and implemented a resource-based relative value schedule that could be used by all state agency healthcare payers, which required policy and data analysis, development of recommendations and implementation of methodology. Clients included Medicaid, Workers Compensation and Uninsured Fund payers. We also reviewed systems requirements and developed requirements document to support implementation.
- Conducted healthcare cost trending analytics designed to identify trend drivers and quantify impact of price, utilization, provider mix and service mix on cost trends. We use analytics to alter assumptions and project future healthcare expenditures.
- Analyzed increases in healthcare costs from year to year in comparison to accepted inflation indices and to payers' increases in premiums and payment levels.

REPRESENTATIVE CLIENTS AND PROJECTS:

Aetna ◆ State of Wyoming Medicaid ◆ State of Georgia Medicaid ◆ Commercial Blue Cross Blue Shield Plans ◆ Commonwealth of Pennsylvania ◆ Blue Cross Blue Shield of Alabama ◆ Queens Long Island Medical Group (QLIMG) ◆ AtlantiCare ◆ Blue Cross Blue Shield of Massachusetts ◆ 1115 Demonstration for State of Wyoming ◆ 1115 Demonstration for State of Idaho ◆ Pennsylvania Department of Public Welfare (DPW) Development of a 1915(b) waiver for ACCESS Plus (the Commonwealth's EPCCM and

D. Alternative Healthcare Delivery Systems

disease management program) ◆ Evaluation of the Pennsylvania, North Carolina and Wyoming Family Planning Waivers ◆ Evaluation of Piedmont Behavioral Health Managed Care Waiver ◆ Pennsylvania DPW 1115 demonstration proposal to Implement Premium Requirements for Select Populations ◆ Ohio 1915(b) and (c) waiver program for behavioral health ◆ Georgia 1915(B) waivers ◆ Indiana 1915(b) waivers ◆ Texas 1115 Demonstration Evaluation ◆ State of New York Grants for Health Insurance Exchange Funding ◆ Developed State Medicaid Health Information Technology Plans in the states of Kansas, Maryland, Pennsylvania and the District of Columbia and assisted with the landscape assessment in Illinois

E. Health Information Exchange (HIE) and Health Information Technology (HIT)

State Medicaid Agencies

Navigant understands the depth of the complexity related to state and Federal HIE and EHR projects and is experienced in the programmatic, technical and organizational challenges that state agencies face when implementing these initiatives. The Navigant team supports states throughout the entire life cycle of their HIE and EHR initiatives – including strategic planning and consensus building processes, business sustainability, stakeholder communications, provider trainings and conducting ongoing administrative and oversight functions. We understand the process as a whole and work with states on the required activities.

We regularly bridge the complex technical requirements of HIE and EHR initiatives. Our expertise in technology and operations enables us to understand, measure and communicate the value of HIE and EHR initiatives. We are also experienced in measuring and promoting provider adoption and meaningful use of EHRs.

Our expertise extends to developing the documents necessary for Federal approval such as State Medicaid HIT Plans (SMHP) and Implementation Advanced Planning Documents (I-APD) and updates for the Medicaid EHR incentive payment program and strategic and operational plans for State HIE Cooperative Agreement programs. The SMHP document includes a great deal of information on the state's plan for designing, implementing, monitoring and evaluating its EHR incentive program. For example, the SMHP describes the state landscape assessment of HIT adoption before and after the implementation of the incentive program (which includes surveys and environmental scans); a plan for moving from the "As Is" state environment prior to the incentive program to "To Be" state vision for HIT over a five to 10 year period; a description of how the state has engaged health professionals, hospitals and other stakeholders; an auditing plan; the incentive program implementation and operations plan; and the state's plan for evaluation the program's success. The I-APD serves as the state's request for federal funding for the incentive program.

E. Health Information Exchange (HIE) and Health Information Technology (HIT)

Our team also has experience in developing business sustainability plans for statewide HIEs. In this process, we estimate the overall savings to the state's healthcare system as well as to the major stakeholder groups expected to realize the majority of the savings – payers and providers (hospitals and physicians) – from implementation of the statewide HIE. We have assisted state staff to identify options for charging participants for use of the HIE once it is operational to support the HIE's ongoing operating expenses. States can use these business plans to demonstrate the financial viability and sustainability of the HIE and market it to encourage potential users to participate.

Examples of Navigant's HIT work with states include:

- Assisting state Medicaid agencies with the development and implementation of its Medicaid EHR incentive payment program
- Drafting SMHP and I-APD documents in strict accordance with Federal guidelines
- Developing the administrative processes related to provider eligibility, education, training, payment and oversight
- Planning and organizing statewide stakeholder engagement process
- Conducting landscape assessment through provider surveys and other research
- Conducting financial impact analyses of the state's HIE Cooperative Agreement Program, which will allow the Medicaid agency to assess the sustainability of the HIE
- Helping state clients to achieve expeditious initial approvals and modification approvals from CMS
- Participation in government and private sector work groups' HIT conferences and other activities
- Regularly speaking and presenting on topics relating to HIT, HIE, EHRs and telehealth to multiple organizations including the Summit Health Institute for Research and Education, the California Primary Care Association, HIMSS Government Roundtable, Association of State and Territorial Health Officials, National Rural Health Association Task Force, Medicaid Directors at the Medicaid Management Information System and the National Association of State Medicaid Directors.

HIT Assistance to Providers

Navigant also offers technical and strategic support to healthcare providers, practices and facilities in implementing EHR and EMR systems and health information exchange and in meeting federal requirements for HIT grants and participating in the meaningful use program.

E. Health Information Exchange (HIE) and Health Information Technology (HIT)

We:

- Assist with facility and practice implementation and conduct evaluations of facility and practice HIT systems including EMRs and practice management systems
- Provide technical assistance and auditing support on meeting the requirements of the Medicaid and Medicare EHR Incentive Program
- Conduct strategic evaluations of facility and practice HIT implementation and use

REPRESENTATIVE CLIENTS AND PROJECTS:

District of Columbia SMHP and I-APD ◆ Maryland Health Care Commission SMHP and I-APD ◆ Pennsylvania EHR Incentive Program, SMHP and other HIT Initiatives ◆ Pennsylvania Five-Year Health Information Exchange Savings and Financial Impact Model ◆ Kansas EHR Incentive Program Design and SMHP and I-APD Development ◆ Illinois Office of Health Information Technology Health Information Exchange ◆ Illinois Department of Healthcare and Family Services Health Information Technology Incentive Payments ◆ Centura Health High Level HIT Evaluation ◆ Stellaris Health Strategic EHR evaluation ◆ Presbyterian Medical Group – Meaningful Use Project Management

F. Preparation of State Plan Amendments (SPAs) and Federal Waiver Submission, Modifications and Renewals

Our consultants regularly work with Medicaid programs across the country on SPA and waiver development, renewal and evaluation projects. Navigant offers experience designing, applying for, implementing and evaluating Medicaid waiver programs. Our team has extensive experience with 1115 and 1915(b) and 1915(c) waivers.

We have been involved in most facets of SPA and waiver development, including working with stakeholders to develop program design, developing the cost-effectiveness analyses, writing the applications, negotiating with CMS, conducting evaluations of the waiver programs and other tasks. Our clients often call upon us to assist with demonstration of Federal compliance and respond to questions from CMS. We regularly help state clients achieve expeditious initial approvals and modification approvals from CMS. We have provided assistance reviewing documentation created by our state clients, assisted with responding to CMS questions during the review process and assisted with meetings with CMS to further program approval.

Waivers, particularly 1115 waiver proposals, can be extremely complex; therefore states must be creative and innovative in developing waiver programs. We help clients write new waiver applications, edit in-process application materials and negotiate with CMS. Our consultants

F. Preparation of State Plan Amendments (SPAs) and Federal Waiver Submission, Modifications and Renewals

have strong relationships with CMS staff, and we are experienced in helping our state clients navigate Federal requirements when applying for Medicaid waivers.

Our consultants continuously research innovations in the waiver process. We are committed to bringing to our clients' attention the latest available options and guiding them through the process as appropriate. This guidance could include the development of work plans, concept papers and the waiver applications.

We understand the critical choices states must make when developing new programs with regard to policy development and planning for the ongoing monitoring of the program. The Deficit Reduction Act of 2005 allows states to make some program changes without submitting waiver applications; states now consider this possibility in their planning decisions.

1115(a) Waiver for Institutions for Mental Disease. Our consultants assisted the State of Idaho in determining the feasibility of using an 1115(a) Research and Demonstration waiver to provide services to persons 22 through 64 years of age in institutions for mental disease. Medicaid currently excludes these services for persons in this age group. We developed an options paper, which identified cost-neutral alternatives and presented research on other states' 1115(a) waiver programs with institutions for mental disease provisions. Using inpatient and institutions for mental disease's claims data, we prepared a cost-effectiveness analysis that indicated that such a waiver would not be cost-effective. As a result, the State decided not to proceed with the waiver application.

REPRESENTATIVE CLIENTS AND PROJECTS:

WAIVER

1115 Demonstration for the States of Pennsylvania, Wyoming, Idaho, Montana, Georgia, Texas ◆ Evaluation of The Pennsylvania, North Carolina and Wyoming Family Planning Waivers ◆ Evaluation Of Piedmont Behavioral Health Managed Care Waiver ◆ Ohio 1915(b) and (c) Waiver Program for Behavioral Health ◆ 1915(b) Waivers for Pennsylvania, Georgia and Indiana ◆ Independent Assessments, External Quality Reviews and Waiver Evaluations for the States of Indiana, North Carolina and Wyoming

STATE PLAN AMENDMENT

SPA Development for California Department of Health Services, Delaware Department of Health and Social Services, Georgia Department of Community Health Indiana Family and Social Services Administration, Iowa, Kentucky Department for Medicaid Services, Maine, Nebraska, New Hampshire, New Jersey and North Carolina ◆ SPA Evaluation for the California Department of Mental Health, Oklahoma, Texas ◆ Boren Amendment Findings Preparation for the State of Oklahoma ◆ Wyoming - Department of Health – SPA related to Federally Qualified Health Center and Rural Health Clinic Rate Analysis, Development and Updates, Inpatient Selective Contracting Program Transition, PACE Optional Service

G. Evaluate Current Supplemental State Funding (CPE, IGT, Provider Tax) Implications Attributable to a Move to the RCO (Regional Care Organization) Model

Navigant has a wealth of experience in helping states understand Federal regulations and guidance in the area of provider assessments and prospective payment systems. We have deep expertise in drafting SPA language related to supplemental payments and related programs and working side-by-side with states and CMS to develop acceptable methodologies that meet both state and Federal objectives. We are experts in CMS regulations governing provider assessments and are cognizant of the provision that requires CMS-compliant provider assessments to be broad-based, uniform and redistributive. Our team members are actively engaged in implementing CMS-compliant solutions to address these regulations.

We have an in-depth understanding of the complexities of assessment ratesetting, having assisted with the design, implementation and maintenance of statewide provider assessment programs in many states. We have extensive experience implementing, modeling and reconciling a variety of provider assessment programs, both statewide and locally. We can attribute our continuing success to our knowledge, creativity and transparency with CMS, and our understanding of the importance of stakeholder communications and buy-in.

Certified Public Expenditure (CPE) Programs

For state Medicaid programs, the Navigant team has substantial experience in the design, development, implementation and ongoing administration of certified public expenditure (CPE) programs. For example, Navigant has evaluated the Medicaid Disproportionate Share Hospital (DSH) and Supplemental payment programs for several states. We documented the programs' purpose and evolution, the states' use of intergovernmental transfer of funds, CPEs and the payment methodology. We also evaluated the programs' compliance with the State Plan and Federal regulations on upper payment limits (UPLs) and analyzed the distribution of payments among hospitals and the equity of the distributions. We prepared reports of the findings of our evaluation along with our recommended changes in the administration and oversight of the programs. We have also recently assisted clients in the analysis of the impact of replacing the use of intergovernmental transfer of funds with CPEs and helped submit a SPA for the CPE model.

SPAs and Inter-Governmental Transfers

Navigant is particularly adept at successfully writing SPAs and responding to CMS questions. We are able to effectively and efficiently develop an SPA that meets all CMS requirements. As part of our work to develop new payment systems, we often supplement the rate development work with draft state plans and rules to support payment systems changes. We work with state agency staff to describe the new system in the state plan and regulations and provide responses to CMS questions regarding the methodologies.

G. Evaluate Current Supplemental State Funding (CPE, IGT, Provider Tax) Implications Attributable to a Move to the RCO (Regional Care Organization) Model

Navigant's state reimbursement work almost always involves supporting state staff through the SPA process. For example, as part of Navigant's work to design and implement payment systems, our consultants have a very hands-on role in drafting related SPA language, assisting with responses to formal and informal CMS questions and assisting with presentations to CMS. We have assisted clients in developing and delivering presentations to public hospitals to explain the CPE program and calculate public hospitals' interim CPEs, as well as hospitals' supplemental and DSH payments.

For inter-governmental transfer (IGT) payment programs, we draft the SPA and assurances that a state's expenditures with the IGT payments will not exceed the UPLs. We support state staff in developing IGT payment estimates and documentation to support the implementation of the SPA and to address compliance requirements. We also evaluate programs' compliance with State Plan and Federal regulations on hospital-specific DSH payment limits and UPLs and analyze the distribution of payments among hospitals and the equity of the distributions. We have assisted states in submitting SPAs to make the payments prospective rather than retrospective and assisted in responding to CMS questions about the SPAs.

We have also assisted clients with the design and implementation of a provider assessment program used to create additional Federal funding to support inpatient and outpatient hospital rate increases. We developed a dynamic model that facilitates the determination of provider tax rates that would be necessary to support desired rate increases and state surplus and at the same time estimates the net fiscal impact to individual hospitals.

REPRESENTATIVE CLIENTS AND PROJECTS:

Design, Implementation and Maintenance of Provider Assessment Programs in the States of Illinois, Pennsylvania, Washington and Vermont ◆ Evaluation of Medicaid DSH and Supplemental Payment Programs in North Carolina ◆ Development and Implementation of Hospital Assessment Programs for the Washington Health Care Authority (HCA), the Illinois Department of Healthcare and Family Services (HFS) and the Pennsylvania Department of Public Welfare

H. Medicaid Information Technology Architecture ("MITA") and Medicaid Management Information Systems (MMIS)

Navigant's extensive payment transformation and quality outcome engagements require a deep understanding of MITA, MMIS data, data flows and system capabilities. Navigant works in concert with state Staff and System Providers (HP, Xerox, etc.) to develop and implement

H. Medicaid Information Technology Architecture ("MITA") and Medicaid Management Information Systems (MMIS)

new processes and procedures required to transform payment models. Our experienced staff provide thought leadership in the development of claims adjudication deliverables used to facilitate accurate and timely payments to Medicaid Providers. These deliverables often include process and procedure manuals; system edits and triggers; and claims monitoring and auditing reports. Our multi-state/multi-vendor experience brings a wide breadth of best practices across challenging implementation landscapes.

Data Security

We have worked with MMIS in virtually every state, assisting in developing one or more reimbursement methodologies. Navigant regularly works with sensitive claims data subject to individual State security and transmission procedures. We conduct secure transactions and carefully maintain the confidentiality of HIPAA-protected data.

MITA Expertise – Navigant Staff

A number of Navigant staff have significant experience with MITA. For example, Betsy Moore has 24 years of MMIS experience and spent seven years creating and implementing a MITA-compliant MMIS for New Hampshire. She and her team built the new system from the ground up rather than from an existing system. As a project manager, she worked with several functional areas of the MITA framework, including claims, financial and payment, and she collaborated extensively with all groups.

In addition, Jason Duhon supported the development of Xerox's Enterprise MMIS, which is MITA level 3 aligned. Mr. Duhon assisted the states of New Hampshire, North Dakota and Alaska with Benefit Plan, Reference, Managed Care and Claims Adjudication design and configuration. He also created General System Design (GSD) and Detail System Design (DSD) documentation for reference and claims adjudication to support implementation of a new Health Enterprise claims processing application. He acted as the lead data analyst of the claims dataset to model migration to new pricing algorithms for a new MITA-aligned Enterprise MMIS. He also designed dynamic auditing functionality which included creating new dynamic, parameterized duplicate checking and utilization review adjudication components for an adjudication subsystem.

MITA Assessment Findings

We have assisted clients in the procurement of MMIS vendors. For one state we collaborated with staff from over 20 functional areas, key agency executives and potential vendors to coordinate meetings, streamline discussions and develop the RFP as well as evaluation and scoring tools. This work involved reviewing current MMIS requirements, drafting the MMIS RFP and identifying and monitoring ongoing procurement issues and activities. We assisted in interactions with potential vendors (e.g., responding to vendor questions, assisting with pre-proposal conference, etc.) and developed tools to support procurement evaluation and scoring.

H. Medicaid Information Technology Architecture ("MITA") and Medicaid Management Information Systems (MMIS)

As part of this MMIS procurement engagement, the Navigant team worked with Commonwealth staff to confirm that systems requirements included in the vendor Request for Proposal were aligned with the Commonwealth's MITA assessment findings.

REPRESENTATIVE CLIENTS AND PROJECTS:

District of Columbia Division of Health Care Finance - State Medicaid Health Information Technology Plan (SMHP) and Implementation Advanced Planning Document (I-APD) ◆ Commonwealth of Pennsylvania Department of Public Welfare, Office of Medical Assistance Programs (OMAP) - Medicaid Management Information System Procurement Assistance ◆ Wyoming Department of Health - Development and implementation of an Ambulatory Payment Classification-based reimbursement system ◆ Arizona AHCCCS - All-Patient Refined DRG Inpatient Hospital Prospective Payment System ◆ Arizona AHCCCS - HAPA Claims Documentation ◆ Medicaid Multi-State Outpatient Prospective Payment System Consortium - Outpatient Prospective Payment System Medicaid Consortium ◆ Commonwealth of Kentucky Department for Medicaid Services - Development of a Diagnosis-Related Group Type Prospective Payment System for Inpatient Hospital Services ◆ Commonwealth of Kentucky Department for Medicaid Services - Procurement of an Administrative Agent

I. Advance Planning Documents (APD)

We have extensive experience with facilitation of healthcare system transformation. We have assisted with Medicaid transformation approaches, and with developing the documents necessary for Federal approvals to implement program reforms. The APD is a formal request to CMS for enhanced Federal funding and grant monies. In exchange, the state agrees to abide by Federal requirements established by CMS. Through the ACA and ARRA, states have the option to seek enhanced funding and grant monies for a number of initiatives, and Navigant regularly assists with the development of APD documents and subsequent updates.

For example, we have developed State Medicaid HIT Plans (SMHP) and Implementation Advanced Planning Documents (IAPDs) for the Medicaid EHR incentive payment program and strategic and operational plans for State HIE Cooperative Agreement programs. We have provided assistance to the Commonwealth of

Our efforts in this area have been quite successful, helping our state clients to achieve expeditious initial approvals and modification approvals from CMS. Having contacts within CMS has helped us to facilitate document reviews, requests for information and CMS approval. We interact with CMS on a weekly if not daily basis.

I. Advance Planning Documents (APD)

Pennsylvania through the lifecycle of this process. We helped Kansas and Nebraska to write SMHPs and IAPDs. We assisted Wyoming to write its Planning Advance Planning Document (PAPD) to secure Federal matching dollars from CMS for planning tasks necessary to develop a vision for capacity expansion and streamlining of the eligibility process across multiple Wyoming assistance programs. We also assisted Pennsylvania with development of two Transformation Grant proposals for submission to CMS.

For these efforts, we often support states in their discussions with CMS. Currently, we are participating in regular meetings of one state with a CMS Medicaid State Technical Assistance Team to discuss Medicaid delivery system changes.

REPRESENTATIVE CLIENTS AND PROJECTS:

Wyoming PAPD for multiple assistance programs ◆ District of Columbia SMHP and I-APD ◆ Maryland Health Care Commission SMHP and I-APD ◆ Pennsylvania EHR Incentive Program, SMHP ◆ Pennsylvania Medicaid Management Information System Procurement Assistance ◆ Kansas EHR Incentive Program Design and SMHP and I-APD Development

J. Healthcare Workforce Transformation

The success of Illinois' new payment and service delivery models will depend largely on the availability and expertise of a trained, multi-disciplinary workforce. We will leverage our broad healthcare service delivery system, regulatory and statutory expertise and implementation capabilities to execute any resulting project with the goal of healthcare workforce transformation.

Navigant has assisted more than 1,000 organizations, hospitals and health systems—including many of the *US News and World Report* Top 100 Hospitals—with projects related to health resource planning. In doing so, we have built a reputation for delivering creative, innovative, and objective services and business advice to our clients. We have an in-house Research and Development department which is composed of Research Analysts dedicated to specific client projects.

In conducting projects like this one, we could utilize a variety of data sources, including but not limited to:

- National Planning Data Corps (NPDC)
- U.S. Census Bureau
- Claritas
- American Hospital Association

J. Healthcare Workforce Transformation

- Medicare Cost Reports [While some of our projects require us to collect cost reports directly from hospitals or the Medicare Intermediary, we also maintain a current file of Medicare Cost Reports for all U.S. hospitals, which is available from CMS through the Healthcare Cost Reporting Information System (HCRIS). The file is updated quarterly and includes all cost reports released during the previous quarter. The file includes both audited and submitted-but-not-yet-audited cost reports.]
- State Licensure Data (Navigant has used state licensure data to identify hospitals in a service area and number of beds in particular categories.)
- Massachusetts Inpatient Database
- CHIPS
- HCIA/Sachs
- Lexis-Nexis
- External Benchmarking [which includes a variety of sources to benchmark operations, including but not limited to: Ingenix "Almanac of Hospital Financial and Operational Indicators;" Ingenix "Hospitalbenchmarks.com; " Rating Agencies (Moody's, S&P, Fitch); and Not-For-Profit Hospital Financial Median Reports]

In addition to these external/public data sources, Navigant has developed a number of proprietary tools and methodologies that will be available for use in this engagement to improve the quality of the work product and support workforce transformation analyses.

We have also worked with a number of states on health resource planning projects and the assessment of hospitals and other providers for various payers. Examples of this work include:

- Developing our *VitalStats* Payment and Network Transformation tool to evaluate cost trends and simulate future state financial scenarios, which may assist payers in the evaluation of provider performance relative to local, regional and national benchmarks, and track cost and utilization performance
- Developing geographic access standards for multiple state Medicaid programs, to facilitate access for beneficiaries to covered services
- Building a Provider Network Database to monitor provider network adequacy for a state's Medicaid program, enabling staff to generate reports on key metrics such as provider-to-member ratios, provider counts, provider additions and deletions and provider terminations
- Conducting a study of rural healthcare for a state to assess current geographic access, provider supply, and patterns of care within the state, which included an

J. Healthcare Workforce Transformation

evaluation of specific types of physicians and facilities to determine the need for additional physicians and inpatient and nursing home beds

- Working collaboratively with multiple agencies within a state to conduct data modeling for rating the relative essentiality and financial viability of acute care hospitals to prioritize financial assistance to financially distressed hospitals, and also recommendations for supporting and dealing with financially-distressed hospitals and approaches for enhancing oversight
- Preparing a comprehensive statewide plan for managing health resources, which encompassed a health resource inventory and working with stakeholders to draft a statewide plan
- Evaluating the compliance of provider network composition of a state's Medicaid and Children's Health Insurance Program (CHIP) Managed Care Organization (MCO) contracts through a Geo-Access assessment using health plan network files

REPRESENTATIVE CLIENTS AND PROJECTS:

PROVIDERS AND PAYERS

Cook Children's Hospital ◆ Health Alliance Plan

STATES

New Jersey Commission for Rationalizing Health Care Resources ◆ Wyoming Department of Health ◆ Pennsylvania Medicaid ◆ Texas Medicaid ◆ Vermont Health Care Administration ◆ Indiana Medicaid ◆ Kansas Medicaid

2. ***List the state(s), territories, and/or tribal entities where your organization has implemented complex healthcare delivery reforms.***

   a.) Describe the focus or components of the reforms that were or are being implemented.

   b.) Include contact information for the referenced implementation(s) and the name(s) of the individual(s) who can verify the status of the implementation(s).

We provide information about a number of key Navigant clients in the narrative that follows. These projects demonstrate experience comparable to that which is necessary for the scope of work requested by Illinois. Should the State require additional references, we would be pleased to provide them.

Georgia Department of Community Health, July 2011 – Present	
Address: 2 Peachtree St. NW, Atlanta, GA 30303	Contact Name: Terri Branning Phone Number: 404.657.7887

Project Name: Georgia Department of Community Health (DCH) Medicaid Transformation

DCH retained Navigant in August 2011 to analyze and implement strategic options for managing the financing and care of the State's Medicaid and PeachCare for Kids™ programs which cover nearly 1.7 million members. Through collaboration with stakeholders, Navigant is assisting DCH with initiatives to support improved outcomes and quality of care.

Navigant conducted an assessment of re-design options for the State. We used a robust, structured, objective and analytic approach to evaluating what is often a politically-charged environment that includes stakeholders and politicians with competing priorities. Navigant initially conducted the following tasks to support development of a ***Comprehensive Design Strategy Report***:

- Assessed the model and structure of Georgia's current Medicaid and PeachCare for Kids™
- Conducted a national environmental scan of Medicaid and Children's Health Insurance Programs and of best practices in commercial health plans
- Collected and evaluated ideas for innovation as well as the financing and delivery of Medicaid and PeachCare for Kids™ benefits
- Assessed delivery system options for any redesign or modification of Georgia's current program to provide Medicaid and PeachCare for Kids™ members access to quality care
- Conducted focus groups across the State with and an online survey of providers, consumers, advocacy groups and vendors

Navigant is currently performing the following activities:

- Supporting task forces and workgroups charged with identifying key program

Georgia Department of Community Health, July 2011 – Present

design components and issues to consider for the proposed delivery systems and program design

- Assisting with strategic planning and development of program design components
- Assisting in planning for and implementation of an expansion of the State's risk-based Medicaid managed care program, Georgia Families, to children in foster care and adoption assistance and select children in juvenile justice; helping the State to build infrastructure, processes and tools to support implementation of the new program (e.g., Readiness Review tools, use case workflows, transition work plans, etc.)
- Supporting the development of key program design features and procurement materials for a new Medical Coordination Program for members who are aged, blind and disabled
- Assisting with the development of a value-based-purchasing strategy and identifying meaningful performance measures
- Participating in and advising on negotiations with CMS about innovative program design features such as opportunities to request alternative funding options
- Preparing documents to obtain federal authority for the program changes the State is implementing

With this project, Navigant has demonstrated proficiency in design, procurement, operation, evaluation and improvement of risk-based and other Medicaid managed care programs.

Navigant recently helped Georgia design a Value Based Purchasing (VBP) model to implement as part of its expansion of Georgia Families to children in foster care, adoption assistance and juvenile justice. This effort will increase opportunities for the State to align all quality improvement efforts across stakeholders. This VBP model goes beyond Pay for Performance – a very clear and transparent goal-setting process is conducted, including mining of data to identify gaps and areas where a focus is needed. Based on the goal or the aim for a given year, the VBP model requires a process to conduct monthly measurement of progress. In recent meetings with the State and the contracted health plan, the CEO of the contracted health plan called Navigant's VBP approach "brilliant" in its ability to align incentives and drive quality improvement. Navigant has advised Georgia through a process that is anticipated to make the State a national leader in Medicaid performance improvement and quality improvement.

We have conducted our work on time and on budget and we are very flexible to modify our work approach to meet our needs. As the State has changed the course of its design options, Navigant has changed course also with the State. We are flexible to support the decisions the State has made about which managed care programs to implement. Navigant always makes arrangements to have key staff on site when needed and to provide subject matter experts on an as needed basis.

Illinois Department of Healthcare and Family Services, 1992 – Present	
Address: 201 South Grand Ave E, Springfield, IL 62704	Contact: Dan Jenkins Phone Number: 217-782-1200

Project Name: Payment Transformation and Other Illinois Medicaid Technical Assistance Projects

Navigant has been working with the State of Illinois for more than 20 years, on back-to-back competitively bid projects.

Long Term Care – Balancing Incentive Program

Starting in May 2013, Navigant started a project to provide policy consulting and technical assistance for Illinois' Balancing Incentive Plan. This Plan will expand LTSS delivery systems and increase accessibility for individuals with chronic conditions by streamlining eligibility assessments and case management across these populations. Technical assistance includes assisting in planning, implementation and coordination of initiatives and program monitoring.

Hospital Rate Reform Initiative

We are currently assisting the Illinois Department of Healthcare and Family Services (the Agency) with its Hospital Rate Reform Initiative by redesigning its Medicaid fee-for-service hospital inpatient prospective payment system. We have advised the Agency on options for transitioning from the current supplemental payment-intensive reimbursement system for hospital services to a claim-based payment system that recognizes the severity of illness and the resources expended on Medicaid patients.

In preparation for the rollout of the Hospital Rate Reform Initiative to the hospital community, we conducted a significant amount of research and analysis for the new inpatient and outpatient systems, and are currently working on a critical segment of the redesign process. Recent work related to the Hospital Rate Reform Initiative includes design, financial projections and rate modeling, impact analysis (by hospital or hospital peer groups), stakeholder meeting facilitation and communications strategies and tools.

Managed Care and Healthcare Reform Initiatives

We have also assisted Illinois with the following managed care and healthcare reform initiatives:

- Assisted with the refinements to Illinois Covered, the health initiative announced by then-Governor Blagojevich to provide universal health coverage to all State residents by 2010. Throughout the 2007 legislative session, we worked closely with senior staff in the Governor's Office, Division of Insurance, Department of Public Health and the State Office of Management and Budget to develop a universal coverage approach involving both public and private health care insurance

Illinois Department of Healthcare and Family Services, 1992 – Present
initiatives. As part of this process, we assisted the State with the development of budgetary impact analyses for this initiative which required a significant financial, actuarial and public and commercial insurance benefits plans expertise, and complex analyses of data describing State population demographics, employer health care spending, and the cost and availability of a wide variety of public and commercial benefit packages. We continued to support the State with ad hoc analyses during the 2008 legislative session as the Governor negotiated with the State Legislature. • Assisted with development and implementation of a statewide Primary Care Case Management (PCCM) program. We developed Requests for Proposals for a Client Enrollment Broker and PCCM Program Administrator. We developed contracts between the State and each of the vendors. We also prepared member education materials and developed a provider handbook for the voluntary phase of the program. We also drafted the linkage agreement between the State, Client Enrollment Broker, PCCM Program Administrator and Disease Management administrator that defined the responsibilities of the State and expectations of the vendors to help ensure cross-program coordination. We are now assisting with oversight of the Agency's various Medicaid managed care programs, including organizational change management, performance measurement and benchmarking and other program management tasks.

3. Complete the following Matrix summarizing the subject of the projects that have been implemented or are in progress. (List each referenced program on a separate line.)

The matrix below provides a summary of Navigant projects that have been implemented or are in process that are similar in scope to the requirements set forth the in the RFI. Following the matrix, we provide a narrative project description for each project listed in the matrix. We have numbered the projects for ease of reference.

Matrix – Summary of Navigant Projects				
State/Territory/Tribal Program Referenced	**Health Reform Implementation Focus/Components**	**Start Date of Implementation**	**Projected Completion Date**	**Project Website**
(1) Banner Health System, Aetna Pioneer ACO Initiative	See project description on the following pages.	April 2011	April 2013	N/A
(2) BlueCross BlueShield Alabama Value-Based Payment Model Strategy and Implementation	See project description on the following pages.	January 2010	Present	N/A
(3) Centers of Medicare and Medicaid Services Consumer Operated and Oriented Plan Technical Assistance	See project description on the following pages.	August 2012	July 2014 (plus three remaining one-year extensions)	N/A
(4) Centura Health and Catholic Health Initiatives (CHI) Medicare Shared Savings Program ACOs and Bundled Payments for Care Improvement Initiatives	See project description on the following pages.	April 2012	Present	N/A
(5) Commonwealth of Massachusetts Massachusetts Medicaid Delivery Model	See project description on the following pages.	October 2012	June 2013	N/A
(6) Georgia Department of Community Health Medicaid Transformation	See project description on the following pages.	July 2011	Present	N/A
(7) HealthEast Care System ACO Development and Clinical Integration	See project description on the following pages.	February 2012	August 2012	N/A
(8) Illinois Department of Healthcare and Family Services Medicaid Initiative	See project description on the following pages.	1992	Present	N/A
(9) Pennsylvania Dept of Public Welfare Technical Assistance and HIT/EHR	See project description on the following pages.	February 1998	December 2013	N/A
(10) Queens Long Island Medical Group (QLIMG), NY Care Coordination and Medical Home Development	See project description on the following pages.	January 2011	Present	N/A
(11) Wyoming Department of Health Medicaid Reform and Wyoming Medicaid Reimbursement Projects	See project description on the following pages.	December 1990	Present	N/A
(12) Idaho Department of Health and Welfare, Division of Medicaid Various Medicaid Reform Program Initiatives	See project description on the following pages.	1996	1999	N/A
(13) Michigan Develop and Conduct Feasibility Study for All-Payer Claims Database	See project description on the following pages.	January 2014	Present *(July 2014 estimated contract end date)*	N/A

(1)

Banner Health System, Aetna

Pioneer ACO Initiative

Project Duration:
April 2011 – April 2013

As a newly designated ACO, Banner Health with a combination of technology and services from Medicity, ActiveHealth, and iTriage, Aetna subsidiaries, began the first stage of their accountable care collaboration relationship. Aetna sought Navigant's assistance and expertise in managing the overall ACO initiative and their newly formed relationship with Banner Health. To ensure success in the creation of an ACO, Aetna, Banner Health, and Navigant created a partnership to move the newly formed ACO from "emerging" to "in practice." Navigant was responsible for facilitating critical conversations and work between Aetna and Banner around envisioning, assessment and analysis, establishing priorities and developing a plan.

To manage the ACO initiative, Navigant created a Steering Committee and several Sub-Committees to assess the organization's core capabilities in the following arenas: operational excellence, leadership and culture, physician alignment, care integration and technology enablement. Out of these committees and the assessment of the core building blocks, a business plan was produced which identified key activities and critical milestones that needed to be met by Aetna and Banner Health. Navigant currently leads the project management of the implementation efforts.

Through Navigant's leadership, expertise and understanding the complexity of both the payer and provider environments, we were able to achieve the following:

- Provided deep analytics on unit cost savings creating a win-win solution for both the payer and provider
- Facilitated product design and management sessions
- Identified key medical cost savings opportunities by provider, type of service, patient type

We also assisted with onsite ACO implementation project management expertise. We provided numerous analyses, such as the following:

- Analysis #1: High level descriptive statistics for the market
- Analysis #2: PMPM trend driver analysis by product, population (e.g., Medicaid); includes analysis of utilization, unit cost, service mix and patient selection patterns vs. Aetna and Navigant benchmarks for potential high level savings opportunities
- Analysis #3: Utilization, cost and service mix drill down by product, population, and hospital using Navigant data, MedPAR, cost report, Truven, etc. to identify hospital-specific savings opportunities at Banner vs. the market

(1) *Continued*

Banner Health System, Aetna

Pioneer ACO Initiative

Project Duration:
April 2011 – April 2013

- Analysis #4: Physician Practice Variation Report showing cost for client in comparison to the market, to connect the PMPM and hospital analytics back to physicians
- Analysis #5: "Scenario Based" Trend Management/Cost Reduction Analysis, to explore several tactics to bend the trend
- Analysis #6: Strategic Alternatives Assessment for Banner
- Analysis #7: Trend Management/Cost Reduction/Avoidable Cost Opportunity Report, using groupers such as Prometheus, etc.
- Analysis #8: Health Management structure, process, outcomes opportunity analysis

(2)

BlueCross BlueShield of Alabama

Value-Based Payment Model Strategy and Implementation

Project Duration:
January 2010 – Present

We assisted BCBS Alabama with the development of its long-term, value-based payment model strategy and implementation for all providers. We assisted with several key activities, including:

- **Data acquisition:** Our data upload process loaded payer and provider data for the Alabama market.
- **Data validation: We used a** standard data validation process to ensure accurate data transmission, e.g., to address data errors including the following:
  - Duplicate claims
  - Missing data fields
  - Negative claim values
  - Claims outside of date range
  - Financial / calculation errors
- **Data pricing –** we completed the following:
  - Integrated rate benchmarks:
    - Re-priced claims at Medicare rates, which enables pricing comparisons to Medicare, a standard industry comparison
    - Integrated market level reimbursement based on claims from more than 40M members nationally in order to compare reimbursement versus market norms
  - Integrated provider cost values:
    - Integrated provider HCRIS (healthcare cost report information system) cost data to estimate provider costs on an individual claim basis to enable calculating provider margins by service type
  - Appended Navigant proprietary mappings to enable segmenting performance by:
    - Service line (e.g., cardiac, orthopedic, neuroscience, etc.)
    - Functional service (e.g., room and board, radiology, supplies, lab, pharmacy, etc.)
    - Cost tiers (e.g., high cost proprietary vs. low cost commodity services)
    - Provider attributes (e.g., tertiary, community, geography, bed size, etc.)

(2) Continued

BlueCross BlueShield of Alabama

Value-Based Payment Model Strategy and Implementation

Project Duration:
January 2010 – Present

- **Data analysis –** We used SAS-based routines to isolate key cost and utilization trends by individual provider, products and geographies. Using our NextGeneration analytic toolkit, we generated automated reports to evaluate Cost savings opportunities:
    - Avoidable costs
    - Hospital acquired conditions
    - Avoidable hospitalizations
    - Avoidable readmissions
    - One day stays
    - Avoidable ancillary services
    - Generic pharmacy utilization rates
- **PMPM trend driver analysis**: Evaluation of medical expense trends segmented to provide insight into cost drivers based on actuarial models to:
    - Pricing trends
    - Utilization trends
    - Service mix trends
    - Provider mix trends
- **Facility profile reports:** Comparison of facility data (segmented by facility type) to compare quality and cost across facilities
- **Physician profile reports:** Comparison of physician profile reports to identify physician practice variation resulting in unanticipated outcomes
- **Payment systems design –** We evaluated potential quality and cost savings opportunities based on specific interventions and customized specialty and facility payment policies which will, over time, result in a higher quality, more cost effective delivery system in the state. This included creating a new physician fee schedule for the state, as well as new durable medical equipment and lab fee schedules. We also recommended specific actions to drive improvements in care delivery
- **Ongoing operational support –** We support the state BCBS plan with a dashboard of metrics it regularly shares with providers to manage new payment models

(3)

Centers for Medicare and Medicaid Services

Technical Assistance to Consumer Operated and Oriented Plans (CO-OPs)

Project Duration:
Base year was August 2012 – July 2013 plus four out year extensions

The Centers for Medicare and Medicaid Services (CMS) recently engaged Navigant to provide "real-time" full-service technical assistance support to Consumer Operated and Oriented Plans (CO-OPs) as these non-profit plans prepare to offer health insurance through the Exchange.

Navigant Healthcare is helping CO-OPs complete readiness requirements, prepare for state licensure, satisfy each of their states' Exchange Qualified Health Plan requirements and plan for the business and service functional infrastructure that must be in place by mid-2013. Our team is guiding and supporting CMS by providing technical assistance to help CO-OPs develop and operate as successful health insurance companies. As a trusted advisor, Navigant is:

- Developing Technical Assistance strategy
- Conducting assessments and readiness reviews
- Assisting in outreach efforts
- Planning in anticipation of overseeing and monitoring CO-OP performance (future activity)
- Conducting onsite visits and consultations
- Providing CO-OP Qualified Health Plan certification education and support
- Assisting CO-OPs with Exchange functions and requirements

Navigant is working with CMS to develop and implement a robust technical assistance strategy to meet the planning, implementation and operational needs of the CO-OPs so that these new, non-profit health plans can meet the expected milestones and start-up dates as outlined in the ACA. This technical assistance strategy will enable CMS to foster each CO-OP's success and identify and diminish barriers to market entry. Navigant's strategy will re-enforce lessons-learned from the Exchange initial roll-out and will be adaptable and flexible over time as Exchange policy decisions are made by the federal government.

(4)

Centura Health and Catholic Health Initiatives (CHI)

Medicare Shared Savings Program ACOs

Project Duration:
April 2012 – Present

Navigant is assisting Catholic Health Initiatives nationwide with the development and implementation of Medicare Shared Savings Program ACOs and Bundled Payments for Care Improvement (BPCI) initiatives in seven markets across the United States. These initiatives are coordinated at the corporate CHI level where Navigant provides system-wide project management and oversight and coordination of core capability development. Designated consulting teams support local implementations of CHI's ACO and BPCI initiatives in each market in:

- **Development of successful ACO applications to the Medicare Shared Savings Program.** This work included assessments of current capabilities and gaps for MSSP participation; analysis of avoidable costs and the potential for shared savings; subject matter expertise and work group facilitation to develop governance structures, shared savings distribution and funds flow models; and full development of the MSSP application.
- **System-level oversight and coordination of capability development.** This work builds on ongoing efforts to develop a standardized system-wide structure and approach related to clinical standards and quality improvement priorities, finance (e.g., budgeting), data analytics, gain sharing, care coordination, patient engagement, physician engagement and vendor selection where capability development requires external resources.
- **Implementation of ACO and BPCI initiatives in compliance with CMS requirements** for data submission, quality reporting, public reporting, certification of providers, beneficiary notification, use of marketing materials and many other requirements. Navigant provides subject matter expertise to clarify compliance requirements and supports work groups in developing and implementing detailed implementation plans.
- **Implementation of accountable care through "Health Neighborhood" models of care delivery.** Health Neighborhoods define local delivery systems that serve all patients regardless of payer. They include physician practices, hospitals, post-acute providers and community services. At Centura Health Navigant works with the leadership of Health Neighborhoods to form task forces and teams that implement the components of the ACO.

CHI's accountable care and bundled payment initiatives are part of a system-wide effort to transform the delivery of care, reduce costs and, ultimately, improve population health.

(5)

Commonwealth of Massachusetts

Massachusetts Medicaid Delivery Model

Project Duration:
October 2012 – June 2013

Navigant recently completed a project for the Commonwealth of Massachusetts Medicaid Delivery Model Advisory Committee (the Committee). The Committee is charged by the Legislature with studying comparative costs and benefits of varied care delivery models for the Commonwealth's Medicaid program, MassHealth. The Committee, whose membership includes executives from Commonwealth government agencies including Medicaid and the Connector Authority, legislators, managed care plan executives and others – retained Navigant to assess MassHealth's current managed care programs and consider new payment and delivery system approaches that will help the Commonwealth achieve its goals for MassHealth. The Committee is studying how two innovative approaches Primary Care Medical Homes and Accountable Care Organizations, may overlay the current managed care system (which is a mix of a primary care case management program and risk-based managed care): Navigant assisted with the following:

- Analyze claims and encounter data to model the impact of various changes in the current system – we examined risk-based vs. Primary Care Case Management expenditures and how these would change if an ACO bundled payment or PCMH model were implemented
- Identifying lessons learned from innovations in the MassHealth programs and implications for the future
- Identifying the support tools and resources needed to implement new delivery models, including information technology/data needs, clinical knowledge, practice supports and financing
- Reviewing models used in other states or in the private sector to better inform possible models for addressing the needs of MassHealth.
- Modeling different payment and delivery options such as implementing patient-centered medical homes, accountable care organization options and other alternative delivery models; we used SAS and SQL to conduct the modeling and prepare summary reports
- Coordinating and leading meetings with various stakeholders groups including payers, providers, government regulators, advocates and others to provide the Committee with stakeholder insights. Within four weeks of initiating the engagement, Navigant organized and completed 14 stakeholder meetings and interviews. We led discussions, presented findings and brought in other experts as needed to support the work of the Committee.

Navigant drafted the Committee's final report of findings, recommendations and implementation strategies for submittal to the legislature and Governor.

(6)

State of Georgia
Georgia Department of Community Health

Medicaid and CHIP Transformation

Project Duration:
July 2011 – Present

Navigant is currently assisting the Georgia Department of Community Health (DCH) to develop strategies for transforming the State's Medicaid and Children's Health Insurance Programs, which cover nearly 1.7 million members. We are working with the Medicaid Executive team. Through collaboration with stakeholders, Navigant is assisting with initiatives to support improved outcomes and quality of care through innovative delivery designs. Navigant developed a ***comprehensive Design Strategy Report*** to recommend redesign options to DCH.

To prepare the report, we conducted the following tasks:

- Assessed the model and structure of Georgia's current delivery systems through staff interviews and review of programmatic reports and data analyses; conducted a national environmental scan, including research and surveys, of innovations in Medicaid and Children's Health Insurance Programs and of best practices in commercial health plans (e.g., PCMHs, ACOs, managed care programs for all members and all services, etc.)
- Assisted with development of DCH communications to stakeholders about the redesign effort
- Facilitated 29 statewide stakeholder focus groups and conducted an online survey
- Assessed delivery system options for redesign recommendations
- Submitted a final report including delivery system reform recommendations for publication that have been reviewed by other states, health plans and CMS as they consider Medicaid delivery system reform.2

Navigant is continuing its work with DCH on this large scale engagement and is supporting two redesign efforts the State elected to implement: development of a Medical Coordination Program for individuals who are aged, blind and disabled and expansion of the State's Medicaid managed care program, Georgia Families, to children in foster care and adoption assistance:

- **Facilitating meetings with an interagency task force and four stakeholder groups** (Provider Task Force; Aged, Blind and Disabled Task Force; Children and Families Task Force; and Mental Health and Substance Abuse Work Group) charged with identifying advantages and disadvantages of the proposed delivery systems and potential program design and planning needs.

[2] An example of our deliverables can be found at the following link (scroll down to the "Redesign Strategy Report - Posted January 2012" header): http://dch.georgia.gov/00/channel_title/0,2094,31446711_175210527,00.html

(6) Continued

State of Georgia
Georgia Department of Community Health

Medicaid and CHIP Transformation

Project Duration:
July 2011 – Present

- **Assisting with strategic planning and development of program design components** as well as contract requirements to expand Georgia Families to children in foster care and adoption assistance.
- **Supporting development and implementation of the Medical Coordination Program**, including identifying key program design features and providing procurement support such as drafting the RFP and assisting with preparations for the proposal evaluation process.
- **Assisting with all aspects of designing and implementing of a Value Based Purchasing (VBP) strategy.**
- **Preparing federal waiver applications** and supporting meetings with CMS about proposed program changes.
- **Providing monitoring support** by assisting with development of an Executive Dashboard Report, reviewing reporting requirements and helping to develop a monitoring infrastructure.

(7)

HealthEast Care System

Accountable Care Organization (ACO) and Clinical Integration

Project Duration:
February 2012 – August 2012

Navigant assisted HealthEast Care System develop an Accountable Care Organization (ACO) and Clinical Integration. This work included:

- Development of ACO and Clinical Integration readiness assessment through interviews with HealthEast Care System executives and clinicians
- ACO and Clinical Integration simulation modeling and straw model development, including value proposition, medical management, technology and infrastructure, and network/affiliation requirements
- ACO financial pro forma model development
- ACO and clinical integration implementation roadmap
- Targeted analytics specific to clinical opportunities to be addressed through ACO and Clinical Integration implementation
- Assistance with CMS's MSSP application

Our approach to this engagement was based on a few core principles based on years of strategic, data driven engagements with the nation's leading payers and providers. This approach includes:

- ***Engaging key stakeholders in the issues that matter most***
- ***Employing a data driven, scenario-based approach***
- ***Pragmatically balancing early wins and process redesign***

We used these key approach elements to guide our work activities – a few highlights of our work to-date include the following:

Conduct ACO Shallow Dive Assessment. We projected, at a high level, the magnitude of this client's opportunities and vulnerabilities related to potential reimbursement cuts and expenses as reform progresses. We identified outstanding analyses/interviews necessary to inform a continuum of strategic ACO alternatives around market opportunity and how the ACO network must evolve over time.

Design "Winning" ACO Business Straw Model Alternatives. Navigant collaborated with the ACO Workgroup to develop a list of ACO implementation alternatives for refinement. Outcomes of this step included the value proposition statement, a Medical management straw model, technology and infrastructure requirements, a financial straw model and network/affiliation priorities.

Generate the 3-5 year High Level ACO Roadmap/Implementation Plan and Potential Pilots. This step included generating the 3-5 year high level road map along with a list of three high priority pilots (e.g., bundles, shared savings, etc.) with particular partners (e.g., payers, providers) that will help self-fund the ACO initiative.

(8)

State of Illinois, Illinois Department of Healthcare and Family Services

Payment Transformation and other Illinois Medicaid Technical Assistance Projects

Project Duration:
1992 – Present

Navigant has been working with the State of Illinois for more than 20 years, on back-to-back competitively bid projects.

Long Term Care – Balancing Incentive Program

Starting in May 2013, Navigant started a project to provide policy consulting and technical assistance for Illinois' Balancing Incentive Plan. This Plan will expand LTSS delivery systems and increase accessibility for individuals with chronic conditions by streamlining eligibility assessments and case management across these populations. Technical assistance includes assisting in planning, implementation and coordination of initiatives and program monitoring.

Hospital Rate Reform Initiative

We are currently assisting the Illinois Department of Healthcare and Family Services (the Agency) with its Hospital Rate Reform Initiative by redesigning its Medicaid fee-for-service hospital inpatient prospective payment system. We have advised the Agency on options for transitioning from the current supplemental payment-intensive reimbursement system for hospital services to a claim-based payment system that recognizes the severity of illness and the resources expended on Medicaid patients.

In preparation for the rollout of the Hospital Rate Reform Initiative to the hospital community, we conducted a significant amount of research and analysis for the new inpatient and outpatient systems, and are currently working on a critical segment of the redesign process. Recent work related to the Hospital Rate Reform Initiative includes design, financial projections and rate modeling, impact analysis (by hospital or hospital peer groups), stakeholder meeting facilitation and communications strategies and tools.

Managed Care and Healthcare Reform Initiatives

We have also assisted Illinois with the following managed care and healthcare reform initiatives:

- Assisted with the refinements to Illinois Covered, the health initiative announced by then-Governor Blagojevich to provide universal health coverage to all State residents by 2010. Throughout the 2007 legislative session, we worked closely with senior staff in the Governor's Office, Division of Insurance, Department of Public Health and the State Office of Management and Budget to develop a universal coverage approach involving both public and private health care insurance initiatives. As part of this process, we assisted the State with the development of budgetary impact analyses for this

(8) *(Continued)*

State of Illinois, Illinois Department of Healthcare and Family Services

Payment Transformation and other Illinois Medicaid Technical Assistance Projects

Project Duration:
1992 – Present

initiative which required a significant financial, actuarial and public and commercial insurance benefits plans expertise, and complex analyses of data describing State population demographics, employer health care spending, and the cost and availability of a wide variety of public and commercial benefit packages. We continued to support the State with ad hoc analyses during the 2008 legislative session as the Governor negotiated with the State Legislature.

- Assisted with development and implementation of a statewide Primary Care Case Management (PCCM) program. We developed Requests for Proposals for a Client Enrollment Broker and PCCM Program Administrator. We developed contracts between the State and each of the vendors. We also prepared member education materials and developed a provider handbook for the voluntary phase of the program. We also drafted the linkage agreement between the State, Client Enrollment Broker, PCCM Program Administrator and Disease Management administrator that defined the responsibilities of the State and expectations of the vendors to help ensure cross-program coordination. We are now assisting with oversight of the Agency's various Medicaid managed care programs, including organizational change management, performance measurement and benchmarking and other program management tasks.

(9)

Commonwealth of Pennsylvania, Department of Public Welfare

Technical Assistance and Health Information Technology / Medicaid EHR Incentive Program Initiatives

Project Duration:
February 1998 – December 2013

Navigant assisted Pennsylvania for more than 15 years, starting at the inception of HealthChoices (the Commonwealth's mandatory Medicaid managed care program) and continuing through HealthChoices ascent to a robust, risk-based managed care program operating statewide. We were critical in all aspects of program implementation, ongoing operations and refinement of the program. We provided expertise in understanding the health plan industry –helping the Commonwealth conduct more rigorous readiness reviews and monitoring activities. We helped design a ground-breaking pay-for-performance program for the HealthChoices program. Over the years, Navigant has also helped the Commonwealth with a number of other major programs and initiatives including its primary care case management program. For that program, Navigant was key in the design phase through implementation, operations and re-procurement.

Because we held a long term multi-year contract, we were flexible to meet unanticipated needs. For example, we brought subject matter experts and national thought leaders to address needs that arose (e.g., HIT, Health Information Exchange, Health Insurance Exchange) and explored new models of healthcare delivery. We assisted with program design, including development and negotiation of waivers and other Federal authorities for traditional and innovative programs. We performed stakeholder outreach, including developing communication strategies and execution for the unique needs of different constituencies. Navigant assisted the Department of Public Welfare on nine objectives:

- **Program Planning and Design** – Supported the Bureau of Policy, Budget and Planning with policy process and program development by assisting with projects such as developing waivers, analyzing proposed program changes, assisting with the development of public issue papers and public meetings and research and state surveys.
- **HealthChoices Contracting** – Assisted the Department with the development of RFPs and contracts to support the procurement of managed care organizations and other managed care contractors to provide services to Medicaid recipients in the Commonwealth.
- **HealthChoices Implementation and Monitoring** – Critical to developing processes, tools and other infrastructure that serve as the foundation of Pennsylvania's successful monitoring efforts. Assisted the Division of Monitoring and Compliance with development and maintenance of monitoring protocols and systems and train staff. Assisted in restructuring the Core Team Monitoring process to streamline managed care organization monitoring to assess contractor performance. Assisted in Readiness Reviews of managed care organizations by performing tasks such as developing databases, conducting desk reviews and participating in on-site reviews.

(9) (Continued)

Commonwealth of Pennsylvania, Department of Public Welfare

Technical Assistance and Health Information Technology / Medicaid EHR Incentive Program Initiatives

Project Duration:
February 1998 – December 2013

- **Independent Enrollment Assistance Program Support** – Assisted the Division of Enrollment Assistance Programs with development of RFPs and contracts for enrollment broker services and administration of primary care case management program and Early and Periodic Screening, Diagnosis and Treatment services. Assisted to develop and maintain monitoring systems, train staff to use monitoring systems and continue to provide support for procurements.
- **Performance Profiling** – Assisted Division of Quality Monitoring to develop Consumer Guides and HealthChoices Trending Reports that use Health Plan Employer Data and Information Sets, Consumer Assessment of Health Plans and specific Pennsylvania performance measures to profile the performance of managed care organizations for Medicaid consumers. Assisted to develop report layouts, compared results against national benchmarks, circulated performance measures and validated these calculations, wrote report text and translated to Spanish. Assisted with design of streamlined comparison reports, data repository and Pay for Performance program design and reporting.
- **Quality Management/Utilization Management** – Assisted Office of the Medical Director to develop monitoring tools and tracking systems. Continued to assist Division of Quality Monitoring to develop and train staff and a variety of ongoing Quality Management/Utilization Management reporting/data analysis initiatives.
- **Special Needs Support** – Worked with the Division of Quality and Special Needs Coordination and Access on projects such as developing monitoring tools to assess the performance of the health plans' Special Needs Units. Assisted with development of internal Division activity reporting, external managed care organization reporting, strategic planning and staff development, cultural competency initiatives, contract monitoring and special initiatives such as monitoring health plan compliance with the Americans with Disabilities Act requirements related to provider access.
- **Program Management and Infrastructure Development** – Assisted in developing public reports: for example, the HealthChoices Annual Report. Assisted the Bureau of Managed Care Operations with strategic planning and training sessions for staff development.
- **Contract Management** – Provided ongoing contract management support, such as subcontracting with experts in the industry as needed, preparing monthly budget and project status reports and maintaining contract management records and reports.

(10)

Queens Long Island Medical Group (QLIMG), NY

Care Coordination and Medical Home Development

Project Duration:
January 2011 – Present

Queens Long Island Medical Group (QLIMG) retained Navigant in January 2011 to manage the practice for three years to include reconfiguring 17 practice sites into a patient-centered medical home (PCMH) delivery model.

We used our Comprehensive Care Management Tool to make recommendations to prepare QLIMG to achieve NCQA certification. We assessed in the following areas:

1) Organizational structure
2) Information technology (EMR, Huddles and Coordination of Care)
3) Metrics and measurement systems
4) Reward systems
5) CCM programs and processes
6) Workplace design
7) Decision Allocation
8) Talent acquisition, development and retention processes

We also developed key tools for implementation project management plan to transition QLIMG.

All practice sites were evaluated for PCMH readiness and a prioritized site list was presented to the QLIMG leadership team including all site Medical Directors. Four sites were chosen to be developed as pilots for the National Committee Quality Assurance (NCQA) 2011 Patient-Centered Medical Home(PCMH) certification process. Although all QLIMG sites received 2008 level 3 certification in early 2011, none of the locations met the care management requirements for 2011 certification. In response, Navigant consultants, in collaboration with QLIMG's largest payer, Emblem Health, developed, staffed and implemented a comprehensive care management program. In September, 2011 Navigant submitted QLIMG's application to NCQA for 2011 level 3 certification. Three other sites are in the process of 2011 application preparation.

(11)

Wyoming Department of Health

- Wyoming Medicaid Reform
- Wyoming Medicaid Reimbursement
- Medicaid policy and financing issues
- Rate analysis and rate setting
- Other data analytics and policy advisory

Project Duration:
December 1990 – Present

Our consultants have been providing technical assistance services to the State of Wyoming Department of Health on a wide range of healthcare reform, Medicaid policy and financing issues for more than 20 years, under 5 continuous competitively bid contracts.

We worked with the Wyoming Department of Health's Healthcare Reform Commission (appointed by the Governor) to assess the availability of healthcare manpower in the State and where there were shortages, made recommendations to increase the number through a variety of mechanisms. For this same Commission, we conducted an evaluation of Medicaid eligibility and the impact of potential changes in eligibility on expenditures for various services. We continue to examine the impacts of eligibility changes on program design and vice versa. We also evaluated the trauma care system – we conducted financial analyses related to the cost of trauma care and developed models for multi-payer options to pay for trauma services. In these studies for the Commission, we facilitated work groups and an advisory group and met with stakeholders throughout the State to understand their concerns and recommendations.

In one of our projects, we developed a selective contracting program to pay for certain specialty services. We developed episodic-based bundling approaches for transplant, neonatal NICU, and extended psychiatric services that bundled in physician, inpatient and outpatient, transportation and other services. We worked with clinicians at the state to develop payment bundles and quality metrics. We helped the State competitively bid the services and developed evaluation criteria based on cost and quality. This program resulted in millions of dollars of savings for the State. Because this program operated under a waiver, we also developed the 1115 waiver and conducted evaluations of expenditures, access to services and quality.

We have worked with Medicaid to develop, implement, monitor and rebase its prospective inpatient hospital level of care reimbursement system, two prospective outpatient hospital reimbursement systems, a federally-mandated prospective payment methodology for federally qualified health centers and rural health clinics, and a physician Resource Based Relative Value Scale fee schedule. We developed an inpatient and outpatient enhanced payment program funded through intergovernmental transfers. We have performed analyses of the State's Medicaid ambulatory surgical center and durable medical equipment payment methodology and assisted with a state payment accuracy measurement study. We have also provided analyses of the use of waiver and non-waiver approaches to expanding health care coverage.

(11) Continued

Wyoming Department of Health

- Wyoming Medicaid Reform
- Wyoming Medicaid Reimbursement
- Medicaid policy and financing issues
- Rate analysis and rate setting
- Other data analytics and policy advisory

Project Duration:
December 1990 – Present

We are currently assisting the State of Wyoming Department of Health, Office of Health Care Financing, with the provision of Medicaid rate analysis and rate setting practices to establish rates for the various reimbursement methodologies employed by the Department. We are responsible for carrying out reimbursement assistance services, including general research, policy analysis, analysis of State and Federal rules and regulations, and administrative support that is necessary to strategically analyze and update reimbursement methodologies. We perform tasks and activities in response to various State and Federal initiatives impacting Medicaid reimbursement strategies and rate setting practices. We assist with research and business analysis, and perform rate studies, at the request of the Department. For each biennium, we develop "Wyoming Medicaid – Strategy for Reimbursement" which evaluates where Wyoming stands with regard to reimbursement in comparison to commercial health plan benchmarks, Medicare and other states. We make recommendations for changes and priorities based on this report. We also assist in the development of the Annual Report, which tracks expenditures, numbers of eligibles, and projects trends in both.

We provide analyses on a quarterly or annual basis for the Wyoming Department of Health's outpatient prospective payment system, inpatient hospital level of care reimbursement system, hospital intergovernmental transfer payment program, hospital disproportionate share hospital (DSH) payment program, physician Resource Based Relative Value Scale (RBRVS) reimbursement system, Federally Qualified Health Centers and Rural Health Clinic rates, and psychiatric residential treatment facility rates.

For these projects, we have used a variety of commercial databases – for example, the Truven benchmarks and Ingenix benchmarks; we used the APR-DRG, MS-DRG and CMS DRG groupers. We have also conducted analyses using 3M' PPR and PPC groupers. We conduct our analysis using paid claims information from the State's Decision Support System using COGNOS. We have direct access to that system to support our policy and financial analyses. We use SAS, Excel and SQL to conduct our analyses.

We are currently assisting the Department with implementation of ICD-10 by identifying reimbursement areas that rely on diagnosis codes for payment and mapping ICD-9 diagnoses to ICD-10 equivalent. We are providing change specifications of the reimbursement criteria to be communicated to the State's Fiscal Agent and testing the updates for impact.

(12)

State of Idaho

Department of Health and Welfare, Division of Medicaid

Various Medicaid Reform Program Initiatives

Project Duration
1996 – 1999

Please note that Navigant provided these serves through its predecessor firm, Tucker Alan.

- ***Comprehensive Medicaid reform***. Our consultants assisted the State of Idaho Department of Health and Welfare with a comprehensive Medicaid reform project. During the first phase of this project, we facilitated and supported the activities of the Governor's Medicaid Reform Advisory Council, a 17-member body appointed by the Governor to develop recommendations for reform. We established a work site at the State and worked on-site throughout the first phase of the project. We also assisted in the conduct of public meetings around the State, conducted research for the Council on various topics, provided technical assistance to the Council's three subcommittees and prepared several reports for the Council, including its final report. The Council's final report, submitted to the Governor in December 1996, included 88 recommendations for reform.
  During Phase II, we assisted the State with implementing those recommendations that were accepted by the Governor. After the Governor announced his reform package, we developed and facilitated a planning session for Department staff as an initial step in the implementation process. Recommendations included implementing a transitional Medicaid program for persons with disabilities, administrative simplifications and stronger fraud and abuse provisions. Once implementation began, we tracked the status of the reform effort for the Department and worked with Department staff to develop an 1115(a) waiver. The proposed waiver program was broad-based and affected persons with disabilities, pregnant women and individuals with high prescription drug costs. We also worked with Idaho's new administration on the waiver program. We educated the administration on the cost-effectiveness of the waiver and developed an issue paper on the advantages and disadvantages of proceeding with the waiver.
- ***1115(a) Waiver for Institutions for Mental Disease***. Our consultants assisted the State of Idaho in determining the feasibility of using an 1115(a) Research and Demonstration waiver to provide services to persons 22 through 64 years of age in institutions for mental disease. Medicaid currently excludes these services for persons in this age group. We developed an options paper, which identified cost-neutral alternatives and presented research on other states' 1115(a) waiver programs with institutions for mental disease provisions. Using inpatient and institutions for mental disease's claims data, we prepared a cost-effectiveness analysis that indicated that such a waiver would not be cost-effective. As a result, the State decided not to proceed with the waiver application.

(12) Continued

State of Idaho

Department of Health and Welfare, Division of Medicaid

Various Medicaid Reform Program Initiatives

Project Duration
1996 – 1999

Please note that Navigant provided these serves through its predecessor firm, Tucker Alan.

- ***Mental Health Carve-out Program Evaluation***. Our consultants conducted an evaluation of a mental health carve-out program for the State of Idaho Medicaid program. The Governor's Medicaid Reform Advisory Council identified several concerns with the delivery of mental health services in Idaho, given the rural nature of the state. The State asked us to study the benefits and disadvantages of mental health carve-out programs which included topics such as cost control, accountability, comprehensiveness, access and quality. We also studied programs in other states, analyzing them across seven characteristics: eligibility, enrollment, covered services, procurement process, provider network, payment and physical health services.
- ***Transitional Medicaid Program Design.*** We assisted the State of Idaho Department of Health and Welfare in the design of a transitional Medicaid program for people with disabilities. We worked with Idaho to develop the program in response to the requests of Medicaid recipients with disabilities. A number of people with disabilities in Idaho expressed the desire to work but the additional income would have made them ineligible for Medicaid benefits. The program design allowed persons with disabilities, who except for their earned income would be eligible for Medicaid benefits, to work and maintain benefits. We partnered with a work group to identify the critical issues facing this population and design a program to meet its needs. We made recommendations regarding eligibility criteria and cost-sharing requirements. We also designed a wrap-around package of benefits for those individuals who obtained employment that offered private insurance. After the work group finalized the program design, we performed an analysis to estimate the cost of the program. The proposed program became one component of Idaho's proposed 1115(a) Personal Responsibility Waiver.

(13)

State of Michigan

Department of Insurance and Financial Services

Develop and Conduct Feasibility Study for All-Payer Claims Database

Project Duration:
January 2014 – Present

Michigan DIFS (Department of Insurance and Financial Services) engaged Navigant Healthcare as a trusted advisor to perform research and analysis regarding the feasibility of establishing an All-Payer Claims Database (APCD) in Michigan. APCDs are being considered by many states as a single source of data derived from medical claims, pharmacy claims, eligibility files, provider files, and dental claims from private and public payers. State decision-makers will use the feasibility study findings in determining whether to move forward with planning and implementation efforts to properly scope and size the Michigan APCD endeavor.

Navigant will research and analyze the current landscape in Michigan and other state approaches with regard to an APCD; research available information related to other state APCD efforts and best practices; review relevant state and federal requirements related to privacy and security; and facilitate and capture stakeholder input. An overarching component of our feasibility study will be to address issues and costs associated with making the Michigan APCD compliant with ACA provisions, HIPAA regulations and all other privacy and security requirements. We will then analyze business needs and formulate alternatives and options for the State in regard to an APCD. Using this information, Navigant will develop the final feasibility study report, lead presentations and discussions related to the proposed APCD and work with State subject matter experts to gain consensus on the best approach and best APCD option for the State.